MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

C4929

Reg. Diat. No. 418

1. PLACE OF DEATH:

County Montgomery

City or town Mt Zion Mont

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Percy Wallace Addison

3.(b) Social Security Number Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife m

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 21 - 1916

8. AGE: Years	Months	Days	If less than one day
29	4	22	..... hrs. ..... min.

9. Birthplace Laytonsville md

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name Seymore Addison

13. Birthplace Laytonsville md

MOTHER

14. Maiden name Leonia M McCabe

15. Birthplace Laytonsville md

16. Informant Seymore Addison

Address Laytonsville md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17-1946 (month) (day) (year)

Cemetery or crematory Brooke Grove Mont

Location Laytonsville md

18. Funeral director Roy W. Barber

Address Laytonsville md

19. 5/16 1946 C.O.Reid Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1946 at 9:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med. Exam 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death Fracture of skull — DURATION: failed instantly

Due to auto accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-14-46

Where did injury occur? Mt Zion (City or town) Mont. (County) Md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury auto accident Injured at work? no

23. SIGNATURE Frank J. Bronhart M. D.

Address Dep. Med. Exam Gaithersburg md. M. D. or other

Date signed 5-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

C4930

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 319 Greenwood Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

MR. MICHAEL THOMAS ANDERSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Florence M. Anderson

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): May 23, 1896

8. AGE:

Years	Months	Days	If less than one day
49	11	23	...hrs. ...min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Plumber - Retired.

11. Industry or business

FATHER

12. Name: Charles H. Anderson

13. Birthplace: Boston, Mass.

MOTHER

14. Maiden name: Margaret Nolan

15. Birthplace: Washington, D.C.

16. Informant: Brother - Mr. Charles H. Anderson, jr.

Address: 305 Greenwood Avenue, Takoma Park, 12, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20, 1946. (month) (day) (year)

Cemetery or crematory: St. Johns Cemetery,

Location: Forest Glen, Md.

18. Funeral director: Arthur Gaskins.

Address: 254 Carroll St. N.W. Takoma Park D.C.

19. May 17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1946, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1946, to May 16 1946, and that I last saw h.. alive on May 16 1946.

Immediate cause of death: Subarachnoid Hemorrhage — DURATION: 7 days

Due to: Hypertension & Arterio-Sclerosis — 10 yrs

Due to: Epithelioma Gastric — 2 yrs.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel Rickards M. D. or other

Address: 917 Eleventh Ave N.W. Date signed: 5/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

64931

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Poolesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Poolesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME HARRY FOSTER ARDINGER

3.(b) Social Security Number 579-09-3709

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Male~~	White	Married

6.(b) Name of husband or wife Norah L Ardinger

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1893 1896

8. AGE: Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace Washington D C (Town, county, and state)

10. Usual occupation Iron Worker

11. Industry or business

FATHER 12. Name William A Ardinger

13. Birthplace Williamsport, Md.

MOTHER 14. Maiden name Anna Amelia Young

15. Birthplace Washington County, Md.

16. Informant Mrs Nora L Ardinger

Address Poolesville, Md

17. ✓ Burial (Burial, cremation, or removal. Which?) Date thereof May 29 1946 (month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location ✓ Washington, D C

18. Funeral director W W Chambers Co.

Address 3077 M St NW Washington D C

19. May 25 1946 Charles W. Elgin Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25 1946 at 11 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to May 25 1946

and that I last saw him alive on May 25 1946

Immediate cause of death	Congestive Heart Failure	3 months
Due to	Arteriosclerosis of coronary arteries	1 year
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Asbur K Johns MD M. D. or other

Address Poolesville Maryland Date signed May 25 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

184a

C4932

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 11 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 2 months 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Jefferson Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. William Henry Baden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 24, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	20	____ hrs. ____ min.

9. Birthplace: Prince Frederick, Md. (Town, county, and state)

10. Usual occupation: Vice President

11. Industry or business: Loan and Trust Company

FATHER 12. Name: Not Available

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant: Washington Sanitarium and Hospital Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/17/46 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Washington D.C.

18. Funeral director: Wm Reuben Quinphrey

Address: Bethesda Md.

19. May 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1946, at 1 15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1946, to May 14 1946

and that I last saw h... alive on May 13 1946

Immediate cause of death	DURATION
Organic heart dis. with Coronary thrombosis	4 Days.
Due to: Generalized Arteriosclerosis	many yrs.
Due to:	
Other conditions: Fracture of L. hip (Accidental fall)	

(Include pregnancy within 3 months of death)

Major findings of operation: no operation

Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stirling Ruffin M. D. or other

Address: 1150 Connecticut Ave. Washington D.C. Date signed: 5/14/46

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(4933

Reg. Dist. No. 213-

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 months
Hospital, Institution, or street address where death occurred: 807- Maple Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 807 - Maple Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Shay Bell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Nathaniel Burr Bell
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): May 6 - 1879

8. AGE:

Years	Months	Days	If less than one day
67	0	2	...hrs. ...min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own Home

FATHER
12. Name: Thomas Shay
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Minnie Howard
15. Birthplace: West Virginia

16. Informant: Mr. Vance Ste. Bell
Address: 807-Maple Ave.-Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10/1946 (month) (day) (year)
Cemetery or crematory: Rockville Union Cem
Location: Near Rockville-Montg. Co.

18. Funeral director: Wm. Reuben Dumphrey
Address: Rockville - Maryland

19. 5/8/46 (Date rec'd by registrar) Josephine D. Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1946, at 12:06 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1946, to May 8, 1946
and that I last saw h... alive on May 8, 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G. H. Hatton, M.D.
M. D. or other
Address: Rockville, Md. Date signed: 5/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

(4934

Reg. Dist. No. 2-6

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Montrose

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Gertrude Bowman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Lucius

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec - 17, 1868

8. AGE: Years	Months	Days	If less than one day
77	5	3	..... hrs. ..... min.

9. Birthplace Hickory Grove, Prince William, Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Palen

13. Birthplace Virginia

MOTHER 14. Maiden name Mary Jane Waddell

15. Birthplace Virginia

16. Informant Robert Bowman (Son)

Address 114 S. Broadway, Balto. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/21/46 (month) (day) (year)

Cemetery or crematory to

Location Rock. D.C

18. Funeral director W. W. Chambers Co.

Address 3511 M St. N.W.

19. 5/21 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1946, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1946, to ..... 19....

and that I last saw h.e.r. alive on May 20 1946

Immediate cause of death	DURATION
Carcinoma of breast	6 days
Due to	
Due to	
Other conditions P.O. pregnancy	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Barbara Moulton M.D. M. D. or other

Address Suburban Hospital Bethesda Md Date signed 5/21/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742 +

CERTIFICATE OF DEATH

(4935

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2253 R St. N.W. Wash., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME
Fred Albert Britten

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Alma A. Britten

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 18, 1871

8. AGE: Years	Months	Days	If less than one day
74	5	16	..... hrs. ..... min.

9. Birthplace: Ill. (Town, county, and state)

10. Usual occupation: Retired.

11. Industry or business

FATHER
12. Name: Micheal Britten
13. Birthplace: Germany (dec)

MOTHER
14. Maiden name: Eva Fey
15. Birthplace: Germany (dec)

16. Informant: Mrs. Alma A. Britten
Address: 2253 R. St. N.W. Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-7-46 (month) (day) (year)

Cemetery or crematory: Abbey Memorial

Location: Arlington, Virginia

18. Funeral director: HUNTEMANN FUNERAL HOME W.H.H.
Address: 5732 Georgia Ave. NW Wash., D.C.

19. 4 May 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 May 19 46, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 April 19 46, to 4 May 19 46 and that I last saw h im alive on May 4, 19 46

	DURATION
Immediate cause of death: Anemia, secondary	one month
Due to: Leukaemia, monocytic	one month
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F. E. CHATARD, Comdr. (MC) USN

Address: US NH Bethesda, Md. M. D. or other

Date signed: 5-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15
5/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04936

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: dead on arrival Suburban Hospital

How long in hospital or institution? 20

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Glen Echo

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION): 10 Nassau Circle - Thirty Ave -

2.(a) If veteran, name war: World War I -

3.(a) FULL NAME: John H. Byers -

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Rachel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 25, 1893

8. AGE: Years	Months	Days	If less than one day
52	11	22	..... hrs. ..... min.

9. Birthplace: D.C. (Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace

MOTHER — 14. Maiden name: "

15. Birthplace

16. Informant: Mrs Rachel Byers (wife) Address: Glen Echo Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-17-46 (month) (day) (year)

Cemetery or crematory: Arlington Memorial Park

Location: Washington Blvd Clarendon Va

18. Funeral director: W. W. Chambers Co

Address: Washington DC.

19. 5/17 19.. Wm E Jones Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1946, at 5-50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 19.. to 19..

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Lobar pneumonia	2 days
Due to: died on way to Hosp.	
Due to: no attending Physician	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: left lobar pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broschart M. D. Dep Med Exam M. D. or other

Address: Gaithersburg Md Date signed 5-17-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4938

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 YEARS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 EAST UNDERWOOD ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GERTRUDE SPICER CAREY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: WILLIAM E. CAREY
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MARCH 7, 1880

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: BALTIMORE MARYLAND (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: GEORGE W. SPICER
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: ELIZABETH KENDIG
15. Birthplace: MARYLAND

16. Informant: William E. Carey Jr.
Address: 112 E. Underwood St. Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington D.C.

18. Funeral director: Francis Hoffman
Address: 3821-14th St. N.W. Wash. D.C.

19. 5/7 1946 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1946, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943 to May 6 1946 and that I last saw her alive on May 6 1946

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Arterio-sclerosis generalized	
with severe Coronary Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas A. Wildman M.D.
Address: 3731-Morrison St NW. Washington, D.C. M. D. or other
Date signed: 5/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (492)

C4957

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital - Bethesda
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. Burnt Mills Hills
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr Albert C. Carl

3.(b) Social Security Number 225-05-1331

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
M	W	

6.(b) Name of ~~husband~~ or wife Peggy T. Carl
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1904

8. AGE: Years	Months	Days	If less than one day
42	3	18	hrs. min.

9. Birthplace SHAMOKIN, Pennsylvania (Town, county, and state)
10. Usual occupation Air Pilot, CAPTAIN,
11. Industry or business PENNA. CENTRAL

FATHER
12. Name DARIUS Carl
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Anna Artley
15. Birthplace Pennsylvania

16. Informant Mrs. Peggy T. Carl
Address Burnt Mills Hills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1946 (month) (day) (year)
Cemetery ~~or crematory~~ Cedar Hill Cemetery
Location Suitland, Pr. Geo. Co., Md.
18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.
19. 5/27/46 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25 1946 at 7:30 A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10-20-45 19 to 5-25 1946
and that I last saw h living alive on 5-25-46 19

	DURATION
Immediate cause of death Metastatic Carcinoma of Lung (Bronchogenic)	1 year 4 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Kenneth F. Laughlin M.D. M. D. or other
Address Suburban Hospital Bethesda Date signed 5-25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

(4939

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery Co -

City or town Rockville & Pike Rockville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4/21/45.

Hospital, Institution, or street address where death occurred:

Waverley Sanitarium.

How long in hospital or institution? 4/21/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town St. Marys City

(If outside city or town limits, write RURAL and give nearest town)

Street No. — Walbone

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Clara Lord Carr.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~ James S. Carr (dead) 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 8th 1886.

8. AGE: Years	Months	Days	If less than one day
59.	5	4	— hrs. — min.

9. Birthplace Pittsburgh Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Her home

FATHER 12. Name Louis M. Lord -

13. Birthplace Meadville, Pa.

MOTHER 14. Maiden name Margaret Mechling

15. Birthplace Pittsburg, Pa.

16. Informant Anna R. Hafner

Address 2720 Wisconsin Ave, N.W. Washington D.C.

17. Disposal (Burial, cremation, or removal. Which?) Date thereof 5/13/46 (month) (day) (year)

Cemetery or crematory Uniondale Cem —

Location Pittsburgh Pa.

18. Funeral director Wm Reuben Dunphrey

Address Bethesda, Md —

19. 5/13/46 (Date rec'd by registrar) Wm E Jabes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946, at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945, to May 12- 1946

and that I last saw her alive on May 13th 1946

Immediate cause of death	DURATION
Coronary thrombosis.	24 hrs.
Due to Arterio-sclerosis	20 years
Due to	
Other conditions Chronic nephritis	2 years

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wheeler O. Hull M. D. or other

Address Bethesda, Md. Date signed May-12-1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-7

CERTIFICATE OF DEATH

04940

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg, Md, (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montg

City or town: Clopper

(If outside city or town limits, write RURAL and give nearest town)

Street No. R 4 Box 43 Gaithersburg (Rural)

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William St Clair, Caulfield

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth H Caulfield

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Aug 28th 1860

8. AGE: Years	Months	Days	If less than one day
(1860) 85	8	28	hrs. min.

9. Birthplace: Maryland (M)

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER

12. Name: John B Caulfield

13. Birthplace: Ireland

MOTHER

14. Maiden name: Estell Caussi

15. Birthplace: Md

16. Informant: Elizabeth H Caulfield

Address: Gaithersburg, Md, R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/46 (month) (day) (year)

Cemetery or crematory: St Rose Cemetery

Location: Chopper Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19. May 27 1946 (Date rec'd by registrar) Alma L Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26, 1946, at 9a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to May 26 1946

and that I last saw h.. alive on May 24 1946

Immediate cause of death: Chronic Myocarditis

DURATION: 10 yrs

Due to: Chronic prostatitis; operation same 7 yrs ago;

Due to: Cellulitis of bladder.

Secondary Uraemic poisoning 3 mo

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Upton D Thomas M.D

M. D. or other

Address: Dawsonville-Boyds Md Date signed 5/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

* (4941) Reg. Diat. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4days + 4hrs.

Hospital, institution, or street address where death occurred:
Suburban Hospital - Bethesda Md.,

How long in hospital or institution? 4days + 4hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1619 Carol Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Charles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1870

8. AGE: Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace Prince Geo. Co. Md.,
(Town, county, and state)

10. Usual occupation Gardener

11. Industry or business

FATHER 12. Name Albert Charles

13. Birthplace England

MOTHER 14. Maiden name unknown

15. Birthplace England

16. Informant Arthur J. Charles

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9, 1946 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington DC

18. Funeral director W W Chambers Co

Address 1400 Chapin St NW

19. 5/7 (Date rec'd by registrar) 19 46 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1946 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1946 to May 6 1946 and that I last saw him alive on May 6 1946

Immediate cause of death	DURATION
Pneumonia, Lobular	2 days
Due to	
Due to	
Other conditions Arteriosclerosis, Generalized.	years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Arteriosclerosis, Generalized, Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically. Lobular

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE DeWitt C. DeSautels, M.D. M. D. or other

Address Suburban Hospital Bethesda Md. Date signed May 7, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C4942

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY

City or town CHEVY CHASE (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred: 125- W. LELAND

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State ~~Md~~ County

City or town Washington D.C. (If outside city or town limits, write RURAL and give nearest town)

Street No. 2153 - California St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mabel S. Cole

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife William R. Cole

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 1- 1875

8. AGE: Years 70 Months Days If less than one day hrs. min.

9. Birthplace Harrisonburg, Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name William Slater

13. Birthplace Va.

MOTHER 14. Maiden name Sarah E. Helphenstein

15. Birthplace Va.

16. Informant Nancy Barnes

Address 125- W. Leland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-27-46 (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington, D.C.

18. Funeral director Joseph Gawler's Sons

Address 1756- Penn. Ave.

19. 5/25 1946 Wm E Jobes Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1946, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4 1944, to May 25 1946 and that I last saw her alive on May 25 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 mo.
Due to Arteriosclerosis	
& hypertension	2 yrs.+
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. R. Huffman M. D. or other

Address 17 Dupont Circle Date signed 5/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4943

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 hrs. + 25 min.
Hospital, institution, or street address where death occurred:
Suburban Hospital-Bethesda-Md.,
How long in hospital or institution? 26 hrs + 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town 7 Locks Rd., Bethesda, Md.,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Master Lloyd W. Cornwell

3.(b) Social Security Number

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
m	w	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1945

8. AGE: Years	Months	Days	If less than one day
9 mon.	9 mon.	25	hrs. min.

9. Birthplace maryland
(Town, county, and state)
10. Usual occupation child
11. Industry or business
FATHER 12. Name Walter Cornwell
13. Birthplace Virginia
MOTHER 14. Maiden name Virgie Able
15. Birthplace Virginia
16. Informant Walter Cornwell
Address 7 Locks Rd. Bethesda, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/46 (month) (day) (year)
Cemetery or crematory Concord Church Cem.
Location Bethesda, Md.
18. Funeral director Wm Reuben Cumphrey
Address Bethesda, Md.
19. 5/28 19 46 Wm E Cobey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25-'46 19 at 12 55 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 24 19 46, to May 25 19 46
and that I last saw h. alive on May 25 19 46

Immediate cause of death	DURATION
ENTERITIS, Acute	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE DeWitt E. DeLawter M.D.
M. D. or other
Address Suburban Hosp. Bethesda, Md. Date signed May 25 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

04944

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~XXXXXXXXXX~~ or street address where death occurred:

1123 Fidler Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. 1123 Fidler Lane (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Richard D. Crompton

3.(b) Social Security Number: 578-22-8840

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Myrtle M.

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 9th. 1875

8. AGE: Years	Months	Days	If less than one day
70	7	27	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Guard. Johns Hopkins Lab.

11. Industry or business

FATHER 12. Name: William Crompton

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Catherine Walsh

MOTHER 15. Birthplace: Ireland

16. Informant: Mrs. Myrtle M. Crompton

Address: 1123 Fidler Lane. Sil. Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 - 8 - 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Prince Georges Co. Md.

18. Funeral director: Warner E Pumphrey.

Address: Silver Spring, Md.

19. May 7 1946 (Date rec'd by registrar) Josephine McHaffie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1946, at 1:35 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to:	
Due to:	
Other conditions: hypertension	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhaus M.D. Med. Exam M. D. or other

Address: Smithsburg Md Date signed 5-8-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (60)

CERTIFICATE OF DEATH

C4945

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred: Montgomery Co. Gen. Hosp. Olney Md.

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Huntinghill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Thomas A. Crown Jr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jessie Crown

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): 3/15/1884

8. AGE: Years	Months	Days	If less than one day
61	1	20	...hrs. ...min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business

FATHER — 12. Name: Thomas Crown

13. Birthplace: Md

MOTHER — 14. Maiden name: Elez Crown

15. Birthplace: Md.

16. Informant: Mrs. Crown

Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-7-46 (month) (day) (year)

Cemetery or crematory: Forest Oak 5-7 1946

Location: Gaithersburg Md

18. Funeral director: Wm. Reuben Humphreys

Address: Rockville, Md.

19. May 5 1946 (Date rec'd by registrar) Gertrude B. Lamb Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/5/46, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/14/46 to 5/5/46 and that I last saw him alive on 5/5/46

Immediate cause of death	DURATION
Pulmonary Embolism	10 mn
Due to: Prostatectomy	4/26/46
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertrophied Prostate

Date of op. 5/26/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: [signature] M. D. or other

Address: Laytonsville, Md. Date signed: 5/5/46

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

64946

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1353 Nicholson St., N. W., Wash., D.C.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DAHL, Eugene Ludwig

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Pearl L. Dahl

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 16, 1892

8. AGE:	Years	Months	Days	If less than one day
	53	11	11	..... hrs. ..... min.

9. Birthplace: Iowa (Town, county, and state)

10. Usual occupation: veteran

11. Industry or business:

FATHER — 12. Name: Carl Dahl

13. Birthplace: Denmark (dec)

MOTHER — 14. Maiden name: Georgiana Peterson

15. Birthplace: Norway (dec)

16. Informant: Wife: Mrs. Pearl L. Dahl

Address: 1353 Nicholson St., N. W.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 29 May 46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES L.L.C.

Address: 14th & Harvart St., N.W., Wash., D.C.

19. 5-27 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 May 19 46 at 3:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 May 19 46 to 27 May 19 46 and that I last saw him alive on 27 May 19 46

Immediate cause of death	DURATION
Congestive foilure	6 mo.
Due to: Coronary artery sclerosis and myocardial infarction	years 4 days
Due to: general arteriosclerosis	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: myocardial infarction + ant. sclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. W. Thompson C. W. THOMPSON, Lt.Cdr.(MC) USNR

M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-27 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

C4947

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 145 Days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 145 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3214 S Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME

William Alexander DEITRICK

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Mrs. Virginia Mayo Deitrick

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 20, 1902

8. AGE:	Years	Months	Days	If less than one day
	44	0	16	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business

FATHER
12. Name: Joseph L. Dietrick
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sue McWhorter
15. Birthplace: Virginia

16. Informant: Mrs. Virginia Mayo Deitrick
Address: 3214 S St. Washington, D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-8-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: George W. Wise Co. J.C.T.

Address: 2900 M St. N.W. Wash., D.C.

19. 6 May 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 May 1946 at 0410 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Dec. 1946 to 6 May 1946 and that I last saw h... im ...alive on 6 May 1946

Immediate cause of death	DURATION
Carcinoma of colon (Rt)	7 mo.
Due to:	.....
Due to:	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations: Ca of Colon with metas- tasis to liver Date of op. Dec, 1945

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. T. KLOPP Lt. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 5-6-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5-10-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

C4948

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Usual residence (Home)~~ or street address where death occurred:

9 Poplar Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9 Poplar Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: J. MILTON DERRICK

3.(b) Social Security Number: 578-10-9173

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Florence S.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 30th. 1893

8. AGE: Years	Months	Days	If less than one day
52	8	10	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Automobile Dealer

11. Industry or business

FATHER 12. Name: Jacob B. Derrick

FATHER 13. Birthplace: Miss.

MOTHER 14. Maiden name: Bernetta E. Howard

MOTHER 15. Birthplace: Washington, D. C.

16. Informant: Mrs. Florence S. Derrick

Address: 9 Poplar Ave. Takoma Park. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-13-1946 (month) (day) (year)

Cemetery or ~~Crematory~~: George Washington Memorial

Location: Prince George's County, Md.

18. Funeral director: Warner E Pumphrey

Address: Silver Spring, Maryland.

19. May 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1946, at 9:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2nd. 1945 to May 10th. 1946

and that I last saw h alive on May 10th. 1946

Immediate cause of death	DURATION
Coronary occlusion	about 1 hour suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J Broschart M. D. Att. Phys. M. D. or other

Address: Gaithersburg Md. Date signed: 5-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45.10M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

★ (4849) Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 hours

Hospital, Institution, or street address where death occurred:
Suburban Hosp.

How long in hospital or institution? 27 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 612 Bonifant St
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Theodore J. Dusterhoff

3.(b) Social Security Number 577-07-7279

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Margaret Dusterhoff

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 16 1906

8. AGE: Years	Months	Days	If less than one day
39	6	5	..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Clerk Wash. Gas & Light Co

11. Industry or business Wash. Gas & Light Co.

FATHER 12. Name Charles Dusterhoff

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Agnes Ebert

MOTHER 15. Birthplace Washington D.C.

16. Informant Wife

Address 612 Bonifant St Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24 1946 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Prince Georges Co. Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring Maryland.

19. 5/24/46 (Date rec'd by registrar) Wm E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 May 1946 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Feb. 1946 to 21 May 1946 and that I last saw h.i.h. alive on 20 May 1946

Immediate cause of death	DURATION
Pulmonary Hem.	
ORRHAGE	
Due to MALIGNANCY OF THE	
CHEST & LUNG	
Due to	
Other conditions MULTIPLE METASTASES	

(Include pregnancy within 3 months of death)

Major findings of operations ABOVE

Date of op. DEC. '45

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. Marshall Leveillee Jr. M.D.
M. D. or other

Address 8648 Georgia Ave Silver Spring, Md. Date signed 21 May '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

Evidence for change in item 12, is shown on Film L. 105-June 3, 1946.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-a)

CERTIFICATE OF DEATH

★ 04959

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 1 day
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: Washington
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1515 W St., S.E., Wash., D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: ★ ✓

3.(a) FULL NAME: EDGE, Isaac Fred

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	MARRIED

6.(b) Name of husband or wife: Mrs. Ruth N. Edge
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 31 January 1894

8. AGE: Years	Months	Days	If less than one day
52	3	20	..... hrs. ..... min.

9. Birthplace: S.C. (Town, county, and state)
10. Usual occupation: veteran
11. Industry or business

FATHER
12. Name: ~~John~~ B. Edge, James H. B.
13. Birthplace: S.C.

MOTHER
14. Maiden name: Rosa Harrelson
15. Birthplace: S.C.

16. Informant: wife: Mrs. Ruth N. Edge
Address: 1515 W. St., S.E. Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-24-46 (month) (day) (year)
Cemetery or crematory: CEDAR HILL
Location: Washington, D. C.

18. Funeral director: Thomas F. Murray Funeral Home L.H.
Address: 2007 Nichols Avenue, Nash., D.C.

19. 5-22 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 May 19 46, at 5:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 19 46 to 21 May 19 46 and that I last saw him alive on 21 May 19 46

Immediate cause of death	DURATION
Pulmonary embolism, post operative	2 wks.
Due to Thrombosis, veins + right leg, varicose	1 Yrs.
Due to Thromboangiitis Obliterans	years
Other conditions: Right lumbar sympathectomy performed to improve circulation in right legs. C.W.S.R.	

(Include pregnancy within 3 months of death)

Major findings of operations: Right lumbar sympathectomy Date of op. 5/4/46
Autopsy results: Massive pulmonary embolism
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. K. Kloos E. K. KLOOS, Lt.(jg)(MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 ✓

5/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (457)

CERTIFICATE OF DEATH

C4951

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montg.

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred: 4710 Edgemoor Lane

How long in hospital or institution? 12 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg.

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4710 Edgemoor Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Edith S. M. Esterling

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Thomas L. 1888

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July 6, 1887

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
58	10	-		

9. Birthplace: Richmond, Indiana (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Charles Moore

13. Birthplace: Richmond, Ind.

MOTHER

14. Maiden name: Laura Gibson

15. Birthplace: Lincoln, Va.

16. Informant: Thomas L. Esterling

Address: Same as above

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 5/7/46 (month) (day) (year)

Cedar Hill Cemetery

Cemetery or crematory

Location: Maryland

18. Funeral director: W. Reuben Pumphrey

Address: Bethesda, Md.

19. 5/6 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1946, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to 19..., and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Asphyxia	Supposed death in kitchen of her home
Due to: Eliminating gas	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 5-5-46

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Bronhart M.D. M. D. or other

Address: Esterling Md. Date signed: 5-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

(4952

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of motber)

State Maryland County Montgomery

City or town Chevy Chase - 15

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4506 Leland Street

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME David W. Fox

3.(b) Social Security Number 169-07-5227

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife Hattie Stuckey

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) December 11, 1881

8. AGE:	Years	Months	Days	If less than one day
	64	5	10	....hrs. ....min.

9. Birthplace Atco, N. J. (Town, county, and state)

10. Usual occupation Estimator & Sales

11. Industry or business Hyde Murphy Co.

FATHER 12. Name Charles M. Fox

13. Birthplace New Jersey

MOTHER 14. Maiden name Mary Connard

15. Birthplace New Jersey

16. Informant Mrs. Hattie S. Fox

Address 4506 Leland St., Chevy Chase 15, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/24/46 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Was Maryland D.C.

18. Funeral director W. Reuben Trumphrey

Address Bethesda, Maryland

19. May 22 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 46 at 7:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med. Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral hemorrhage	1/2 hr.
Due to	
Due to	
previous cerebral hemorrhage	
Other conditions 5 yrs ago	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brockett M.D. Dep Med. Exam. M. D. or other

Address Gaithersburg, Md. Date signed 5-21-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1440)

CERTIFICATE OF DEATH

File C4953

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elsie May Gibson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	Colored.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 30, 1928

8. AGE:

Years	Months	Days	If less than one day
17	4	18	hrs. min.

9. Birthplace Montgomery Co. Md (Town, county, and state)

10. Usual occupation Housework.

11. Industry or business Home.

FATHER

12. Name Raymond Gibson

13. Birthplace Virginia

MOTHER

14. Maiden name Viola Dorsey

15. Birthplace Maryland.

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1946 (month) (day) (year)

Cemetery or crematory Emory Grove Ch. Cem.

Location Emory Grove, Md.

18. Funeral director Robert B. Snowden

Address Rockville, Md.

19. May 21 1946 Gertrude B. Lawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1946, at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1946, to May 18 1946 and that I last saw h.e.v. alive on May 18 1946

Immediate cause of death	DURATION
acute Parenchymatous nephritis	3
Due to Eclampsia	2 weeks
Due to Pregnancy 7 mos	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. R. B. M. D. or other

Address Sandy Spring, Md. Date signed 5/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

C4954

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Montrose

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Montrose

(If outside city or town limits, write RURAL and give nearest town)

Street No. None

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME FRANK IVA GREENWALT

3.(b) Social Security Number 578-01-8682

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mae Cummings Greenwalt

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) April 22, 1901

8. AGE: Years	Months	Days	If less than one day
45	0	20	hrs. min.

9. Birthplace Middletown, Va. (Town, county, and state)

10. Usual occupation Real Estate

11. Industry or business

FATHER 12. Name Frank Greenwalt

13. Birthplace Virginia

MOTHER 14. Maiden name Ella Pitts

15. Birthplace Alexandria, Va.

16. Informant Mrs. Frank Iva Greenwalt

Address Montrose, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1946 (mouth) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location Rockville, Maryland

18. Funeral director Wm. Reuben Rumpf

Address Bethesda, Maryland

19. 5/13 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946, at 9:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on 5/12 1946, to 19..... and that I last saw h.. alive on 5/12 1946

Immediate cause of death	DURATION
Coronary Thrombosis	1 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Brent. Benjamin M.D. M. D. or other

Address Bethesda, Md. Date signed 5/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

★ C4955

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 1-M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 3/4 hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1436 Meridian Place, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mamie L. Grimes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cauc.	Widowed

6.(b) Name of husband or wife: Jack Grimes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 28, 1872

8. AGE: Years: 73 Months: 7 Days: 18 If less than one day: hrs. min.

9. Birthplace: ~~Fauquier Co.~~ Virginia (Town, county and state)

10. Usual occupation: House wife.

11. Industry or business:

FATHER 12. Name: Baawoolya Marsteller

13. Birthplace: ?

MOTHER 14. Maiden name: Mary Chadwell

15. Birthplace: ?

16. Informant: Records - Washington San. & Hosp.

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 16-1946 (month) (day) (year)

Cemetery or crematory:

Location: Managasen, Va.

18. Funeral director: Geo. D. Baker & Sons

Address: Manassas, Va.

19. May 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1946, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1946, to May 16, 1946 and that I last saw her alive on May 15 1946

Immediate cause of death	DURATION
Coronary thrombosis	3-4 d.
Due to: Cardiac infarction	
Due to: Chr. Colitis	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul V. Starr, M.D. M. D. or other

Address: Takoma Park, Md., Date signed 5-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

14956

Reg. Diut. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL und give nearest town)

Street No. 1150 17th St.,N.E.,Apt.4, Wash.,D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: GRIMM, Harry Gilbert, V.A.P.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Married

6.(b) Name of husband or wife: Mrs. H. G. Grimm

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 26, 1888

8. AGE:	Years	Months	Days	If less than one day
	57	4	29	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: veteran

11. Industry or business:

FATHER — 12. Name: Hunter B. GRIMM

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Emma ANDERSON

15. Birthplace: Virginia

16. Informant: wife: Mrs. H. G. Grimm

Address: 1150 17th St., N. E., Apt. 4, Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Mt. Hebron

Location: Winchester, Virginia

18. Funeral director: W. W. CHAMBERS, Poone

Address: 517 11th Street, S.E., Wash., D.C.

19. 5-25 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 May 19 46 at 8:26 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 May 19 46 to 25 May 19 46 and that I last saw him alive on 25 May 19 46

Immediate cause of death: Valvular Heart Disease, Aortic Stenosis — DURATION: 3 yrs.

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.: —

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. W. THOMPSON, Lt.Comdr.(MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-5-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

04957

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: Montgomery
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8101 - Rockville Pike
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: GEORGE ERNEST HAMILTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife: Louise Merrick Hamilton 6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Mar 6 - 1854

8. AGE: Years	Months	Days	If less than one day
92			hrs. min.

9. Birthplace: La Plata, Md. Chas. Co. (Town, county, and state)
10. Usual occupation: Lawyer Retired
11. Industry or business
12. FATHER Name: JOHN HAMILTON
13. FATHER Birthplace: PRINCE GEORGE Co. MD
14. MOTHER Maiden name: MARY EMILY HAWKINS
15. MOTHER Birthplace: CHARLES Co. MD.
16. Informant: Geo. E. Hamilton Jr.
Address: 2330 - Wyoming Ave NW
17. (Burial) cremation, or removal. Which?) Date thereof: 5-27-46 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Wash D.C.
18. Funeral director: Jos. Gawler's Sons
Address: 1756 - Pa. Ave NW
19. 5/25 1946 Wm E Jalbert
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1946, at 8:40 p.m.
I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945, to May 24 1946
and that I last saw h. alive on May 24 1946

	DURATION
Immediate cause of death: Pulmonary Edema	12 hrs.
Due to: Coronary artery sclerosis	3 yrs.
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wallace M. Yater, M.D. M. D. or other
Address: 1150 Conn. Ave., NW Date signed: 5/24/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4958

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Boyds.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Preston Hargitt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Thelma Hargitt

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): January 24, 1908

8. AGE:

Years	Months	Days	If less than one day
38	4	1	...hrs. ...min.

9. Birthplace: Madison, Indiana
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Victor Hargitt
13. Birthplace: Dearborne, Indiana.

MOTHER
14. Maiden name: Estella A. Lee
15. Birthplace: Fairland View, Indiana

16. Informant: Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26-46 (month) (day) (year)

Cemetery or crematory: Greenwood

Location: Indianapolis, Ind.

18. Funeral director: William B. Hilton

Address: Barnesville, Md.

19. 5-25-1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1946, at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1946, to May 25 1946 and that I last saw h.i.m. alive on May 25 1946

	DURATION
Immediate cause of death: Pneumonia Bronchitis	5 days
Due to: Lobar Pneumonia	10 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. M. B. M. D. or other

Address: Sandy Spring, Md. Date signed: 5/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

CERTIFICATE OF DEATH

04959

Reg. Dist. No. 213-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Rockville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montg.

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Westmore, Rosewood Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margret Ford Harrell.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife Harrison S. Harrell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 12 1851

8. AGE: Years 94 Months 8 Days 16 If less than one day ..... hrs. ..... min.

9. Birthplace St. Clare — Michigan (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housekeeping.

FATHER 12. Name Daniel Dench.

13. Birthplace Scotland

MOTHER 14. Maiden name Christiana Kennedy

15. Birthplace Scotland

16. Informant Miss Mary Harrell

Address Westmore - Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-1-46 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery.

Location Boonsboro, Washn Co Md

18. Funeral director Wm. T. Bast & Sons

Address Boonsboro, Washn Co Md.

19. 5/30/46 (Date rec'd by registrar) Josephine D. Hatton. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1946, at 1.50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1946, to May 30 1946 and that I last saw her alive on May 29 1946

Immediate cause of death

(a) Acute Congestive Myocarditis — DURATION 4 da

Due to (b) Senile decay.

Due to (c)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Upton D. Howard M.D. M. D. or other

Address Rockville Md Date signed 5/30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04960

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hosp. Bethesda Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 58 St Paul St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY ISABELLE HATHAWAY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband ~~or wife~~ Harold B.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 4 - 1876

8. AGE: Years 70 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Jackson County, Ind. (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER 12. Name Wilbur E Carr

FATHER 13. Birthplace Ohio.

MOTHER 14. Maiden name Margaret Costello

MOTHER 15. Birthplace Ind.

16. Informant Mrs Fredrick B Klein

Address 58 - St. Paul St Kensington Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 12-1946 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director W. W. Chambers Co

Address Washington D.C.

19. 5/12 19 46 Wm E Jobes

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1946, to May 12 1946

and that I last saw h[illegible] alive on May 11 1946

Immediate cause of death ..... DURATION

Cerebral hemorrhage ..... 5 days.

Due to Chr. arteriosclerosis ..... 10 yrs

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. G. Baumgardner M. D. or other

Address Bethesda, Md. Date signed 5-12-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

04961 Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Barnesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 90 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Montg
City or town: Barnesville, Md (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ida Lee Hays

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Frederick P. Hays
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 21 - 1854

8. AGE: Years	Months	Days	If less than one day
91	6	10	..... hrs. ..... min.

9. Birthplace: Leesburg, Loudoun, Va (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Christian Hempstone
13. Birthplace: Va.
MOTHER 14. Maiden name: Mary Dade
15. Birthplace: Va.
16. Informant: Mrs Mary Darby
Address: Barnesville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4 - 1946 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Bedllsville, Md
18. Funeral director: William B. Hilton
Address: Barnesville, Md.
19. May 3 1946 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. C.C.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2nd - 1946, at 2:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/20 - 1942, to May 2 - 1946
and that I last saw h[illegible] alive on May 1st - 1946

Immediate cause of death	DURATION
arteriosclerosis	10 yrs -
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Byron D. White, M.D. M. D. or other
Address: Barnesville, Md. Date signed: 5/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

64962

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Days
Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital, Bethesda, Md.
How long in hospital or institution? 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Couoty:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1140 22nd St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sevear Samuel HENRY V.B.P.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Mrs. Rose Henry
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 12, 1899

8. AGE:	Years	Months	Days	If less than one day
	46	4	22	hrs. min.

9. Birthplace: TENNESSEE
(Town, county, and state)
10. Usual occupation: Messenger
11. Industry or business
FATHER 12. Name: Lizzie Jones
FATHER 13. Birthplace: Georgia
MOTHER 14. Maiden name: Andy Henry
MOTHER 15. Birthplace: Georgia
16. Informant: Mrs. Rose Henry
Address: 1140 22nd St. NW Washington, D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof 5-9-46 (month) (day) (year)
Cemetery or crematory: Arlington, National
Location: Arlington, Virginia
18. Funeral director: Ernest W. Jarvis J.F.D.
Address: 1432 U St. N.W. Wash., D.C.
19. 5 May 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 May 1946 at 8:25 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 April 1946 to 4 May 1946 and that I last saw him alive on 4 May 1946

Immediate cause of death	DURATION
Cirrhosis, Liver atrophic	
Due to: Syphilis, Tertiary, aortitis with aortic regurgitation	
Due to: Bronchopneumonia	
Due to: Malnutrition, extensive	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Autopsy results: Confirmed above with following addition Hemorrhage, cerebellar
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Shuler
J. B. SHULER, Comdr.(MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

5/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

04963242

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days.

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2833 Mayfield Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Elizabeth Horner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	Cauc.	Widowed

6.(b) Name of husband or wife: Jacob Horner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1881

8. AGE: Years	Months	Days	If less than one day
64	8	0	hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Peter Paul Mehr
13. Birthplace: Switzerland

MOTHER
14. Maiden name: --
15. Birthplace: --

16. Informant: Records - Washington San. & Hosp.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16, 1946 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Baltimore, Md.

18. Funeral director: Wm. J. Trahnen & Sons

Address: No. 4 Pa. Ave., Balt. Md.

19. 5/14/1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1946, at 6:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1946, to May 13 1946

and that I last saw h[illegible] alive on May 12. 1946

Immediate cause of death: Coronary Occlusion — DURATION: Terminal

Due to: Atherosclerosis — years

Due to:

Other conditions: Pulmonary Infarcts

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirm above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Ware M.D. M. D. or other

Address: Takoma Park Md. Date signed: 5/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

64964

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Westgate
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Westgate
(If outside city or town limits, write RURAL and give nearest town)
Street No. 202 Baltimore Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: KATHRYN WING HOUK

3.(b) Social Security Number: 281-10-4069

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	DIVORCED

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 28, 1879

8. AGE: Years	Months	Days	If less than one day
67	1	1	hrs. min.

9. Birthplace: Zanesville, Ohio (Town, county, and state)
10. Usual occupation: Retired Newspaper service
11. Industry or business: Newspaper
FATHER 12. Name: Isac Wing
13. Birthplace: Ohio
MOTHER 14. Maiden name: Elizabeth (Unknown)
15. Birthplace: Ohio
16. Informant: Mrs. W. H. Mylander
Address: 202 Baltimore Ave., Westgate, Md.
17. Shipment (Burial, cremation, or removal. Which?) Date thereof May 30, 1946 (month) (day) (year)
Cemetery or crematory: Oak Dale Cemetery
Location: Urbana, Ohio
18. Funeral director: W. Reuben Pumphrey
Address: Bethesda, Maryland
19. 5/30/1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1946, at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	4 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchat M.D. M. D. or other
Address: Sept. Med. Exam Date signed 5-30-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

C4965

Reg. Diat. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Clarksburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Clarksburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen A. Hurley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 24 - 1866

8. AGE: Years	Months	Days	If less than one day
80	2	10	...hrs. ...min.

9. Birthplace Montgomery Co Md (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

FATHER 12. Name John A. Hurley

FATHER 13. Birthplace Montgomery Co Md

MOTHER 14. Maiden name Frances M Richardson

MOTHER 15. Birthplace Montgomery Co Md

16. Informant Madeline V. Scott

Address Damascus Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7-1946 (month) (day) (year)

Cemetery or crematory Clarksburg Md

Location Montgomery Co Md

18. Funeral director Chas W. Barber

Address Rayburnville Md

19. May 6 1946 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 19 46, at Rockville Md

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 Ecam 19... to ... 19... and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	Some months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bronhard M. D. M. D. or other

Address Gaithersburg Md Date signed 5-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ 04966

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County: Montgomery
City or town: Boyds
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7½ years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Boyds
(If outside city or town limits, write RURAL and give nearest town)
Street No. ~
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alfred C. Kaufman

3. (b) Social Security Number ~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ethel E. Kaufman
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): March 22 — 1885

8. AGE: Years	Months	Days	If less than one day
1885 61	1	23	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: farming
11. Industry or business: farm
FATHER 12. Name: John H. Kaufman
FATHER 13. Birthplace: unknown
MOTHER 14. Maiden name: Rebecca Heiney
MOTHER 15. Birthplace: Pennsylvania
16. Informant: Ethel E. Kaufman
Address: Boyds, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/46 (month) (day) (year)
Cemetery or crematory: Quentin Cemetery
Location: Quentin, Penna.
18. Funeral director: E. L. Gaither
Address: Gaithersburg, Md.

19. May 16 1946 Alvida L. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May - 15 - 1946, at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec - 16 - 1943 to May - 15 - 1946 and that I last saw him alive on May - 15 - 1946

Immediate cause of death	DURATION
Acute heart failure	8 hours
Due to: Myocardial degeneration	2 years
Due to: High arterial tension	2 "
Due to: Nephritis parenchymatous	2 "
Due to: Cerebral hemorrhage	2½ yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William E. Mills M.D. M. D. or other
Address: Gaithersburg, Md. Date signed: 5/15/46

Evidence for addition of date of death is shown on FILM No. I 0 4 MAY 14 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96)

CERTIFICATE OF DEATH

04967

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery Co
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Sanitarium Comp.
How long in hospital or institution? 5 ½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4832- Chevy Chase Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: H. Robert Kearney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Ida L. Kearney
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 26 1878

8. AGE: Years	Months	Days	If less than one day
67	7	9	hrs. min.

9. Birthplace: Wash. D.C. (Town, county, and state)
10. Usual occupation: Automobile Dealer Ret.
11. Industry or business

FATHER
12. Name: Patrick H. Kearney
13. Birthplace: Dublin Ireland

MOTHER
14. Maiden name: Catherine Sweeney
15. Birthplace: Dublin Ireland

16. Informant: Mrs. Mary E. Nadeau Daughter
Address: 4832 Chevy Chase Blvd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Hyattsville Rd. S.E. Wash. D.C.

18. Funeral director: The S. H. Kines Co
Address: 2901-14-st. N.W. Wash. D.C.

19. 5/8 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1946 to May 4 1946 and that I last saw h. alive on May 4 1946

Immediate cause of death: Internal Haemorrhage — DURATION
Due to: Aort. Aneurysm
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. A. Martens MD
Address: Bethesda Md. M.D. or other
Date signed: May 5 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

04968

Reg. Diat. No. 514

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~How long in U.S.~~ or street address where death occurred:
508 Ashford Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 508 Ashford Road
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: GRACE ISABEL KENEIPP

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife: Charles L.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 5th. 1876

8. AGE: Years	Months	Days	If less than one day
70	4	11	hrs. min.

9. Birthplace: Florence, Mass. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William VanSkyle
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary Klager
15. Birthplace: Germany

16. Informant: Mrs. L. James Falck
Address: 508 Ashford Rd. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-1946 (month) (day) (year)
Cemetery or ~~crematory~~: Rock Creek
Location: Washington, D. C.
18. Funeral director: Warner Humphrey
Address: Silver Spring, Md.

19. May 17, 1946 (Date rec'd by registrar) Josephine M. Schaeffe, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1946, at 12:00 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945, to May 16 1946
and that I last saw h.. alive on May 16 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 months
Due to Coronary Failure	3 hrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. B. Landay M. D. or other
Address: 243 Bayard St. Date signed: 5/18/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

64969

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 110 Sunnyside Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: STELLA M. KLINE

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband: ~~xxxx~~ Ernest A. Kline

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 4, 1878

8. AGE: Years	Months	Days	If less than one day
68	4	10	..... hrs. ..... min.

9. Birthplace: Easton, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: Alford M. Meyers

FATHER 13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Elizabeth Fern

MOTHER 15. Birthplace: Pennsylvania

16. Informant: Ernest A. Kline

Address: 110 Sunnyside Rd., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, Pr. Geo. Co., Md.

18. Funeral director: Warner C. Pumphrey

Address: Silver Spring, Md.

19. 5/14 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

9:30 A.

20. DATE OF DEATH: May 14 1946, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8th 1945, to May 14 1946 and that I last saw h~~im~~er alive on May 13th 1946

Immediate cause of death	DURATION
Metastatic Carcinoma	—
Due to: Carcinoma of Gall Bladder	—
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Gall Bladder with Metastases. Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Marion Bamhead M.D. M. D. or other

Address: 601 Eastern Ave. Silver Spring, Md. Date signed: 5/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04970

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Mont

City or town: Mt Lay Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Rockville R-3

How long in hospital or institution? Not

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Life County: Mont

City or town: Mt Lay Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rockville R-3
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Wilford James Knight

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	sing

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 15 - 1945

8. AGE: Years: 0 | Months: 11 | Days: 25 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Mont Co Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Jas H. Knight
13. Birthplace: Mont Co Md

MOTHER
14. Maiden name: Thelma M. Burris
15. Birthplace: Mont Co. Md

16. Informant: Jas H. Knight
Address: Rockville R3 - Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 5/15/46
(month) (day) (year)

Cemetery or crematory: Layhill Church Cem

Location: Layhill, Md

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Md

19. May 15 1945
(Date rec'd by registrar)
Gertrude B. Lawls
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 - 1946, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 - 1946, to May 13 1946
and that I last saw h[illegible] alive on May 13 - 46 1946

Immediate cause of death	DURATION
Broncho Pneumonia	24 hrs
Due to: Measles	6 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles Tunnicliff M. D. or other

Address: Sandy Spring Md Date signed: 5-13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04971

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Capitol View Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

[illegible] or street address where death occurred:

Warner Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Capitol View (Silver Spring)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Warner Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: ELIZABETH J. KNUPFER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: George Christian

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 11th. 1866

8. AGE: Years	Months	Days	If less than one day
79	6	9	....hrs. ....min.

9. Birthplace: Wisconsin (Town, county, and state)

10. Usual occupation: Retired Housewife

11. Industry or business

FATHER

12. Name: Watson W. Cook

13. Birthplace: Canada

MOTHER

14. Maiden name: Judith Unknown

15. Birthplace: Wisconsin

16. Informant: Mrs. Charles E. Sando

Address: 6205 - 14th. St. N. W. Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-22-1946 (month) (day) (year)

Cemetery or crematory: Glenwood

Location: Washington, D. C.

18. Funeral director: Warner E Pumphrey

Address: Silver Spring, Md.

19. May 21 1946 (Date rec'd by registrar) Josephine M Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1946 at 1:25 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 16 1945, to May 20 1946 and that I last saw h... alive on May 19 1946

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: Sclerosis of arteries	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J Marion Bamshead MD M. D. or other

Address: Silver Spring, Md Date signed: 5/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

222 Sherman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

C4972

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 11 mo. 12 days.

Hospital, Institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 2 yrs. 11 mo. 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1350 Longfellow St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Daniel C. Leahy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cauc.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1856

8. AGE: Years 89 | Months 7 | Days 0 | If less than one day ..... hrs. ..... min.

9. Birthplace Conn (Town, county, and state)

10. Usual occupation Retired physician

11. Industry or business

FATHER 12. Name Unk

13. Birthplace "

MOTHER 14. Maiden name Unk

15. Birthplace "

16. Informant Records - Washington San. & Hosp.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14, 1946 (month) (day) (year)

Cemetery or crematory Rock Creek Cem.

Location Rock Creek Church Rd. N.W.

18. Funeral director The Altheimer Co

Address 2401 - 14th St. N.W. Washington D.C.

19. May 12 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1943 to May 12 1946 and that I last saw h... alive on May 11 1946

Immediate cause of death	DURATION
Hypostatic Pneumonia	Terminal
Due to	
Due to	
Other conditions Arteriosclerosis	Years.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert Abare M.D. M. D. or other

Address Takoma Park, Md. Date signed 5/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

04973

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 200 Chamberlin Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Charles Pennington Lukens

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Mabel Lukens
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 13. 1870
8. AGE: Years: 75 Months: Days: If less than one day: ..... hrs. ..... min.
9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: Marshall Lukens
13. Birthplace: Pa.
MOTHER 14. Maiden name: Martha McClenaghen
15. Birthplace: Pa.
16. Informant: Charles P. Lukens Jr.
Address: 200 Chamberlin Ave. Bethesda Md.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MAY 18, 1946 (month) (day) (year)
Cemetery or crematory: PRESBYTERIAN CHURCH CEMY
Location: ATGLEN PENNA.
18. Funeral director: Joseph Gawler's Sons
Address: 1756 Pa. Ave. N.W. Wash. D.C.
19. 5/17 1946 Wm E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1946, at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-23 1943, to 5-16 1946
and that I last saw him alive on 5-15 1946

	DURATION
Immediate cause of death: Coronary Heart Desease	18 mos.
Due to: Arteriosclerosis	3yr+
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. R. Hagerman M. D. or other
Address: 17 Depot Circle USPHS Date signed: 5-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Dist. No. 04974 211

1. PLACE OF DEATH:
County Montgomery Co.
City or town Burdum not R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Seven years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Burdum not R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James L McClure

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Jennie A McClure
6.(c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) Oct 23 - 1865 1850

8. AGE: Years	Months	Days	If less than one day
95	6	11	hrs. min.

9. Birthplace Millvill N.J. N.J.
(Town, county and state)
10. Usual occupation Glass Blower
11. Industry or business Glass
FATHER 12. Name James McClure
13. Birthplace England
MOTHER 14. Maiden name Anna Cantwell
15. Birthplace England
16. Informant Mrs Jennie A McClure
Address Monrovia Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6-1946 (month) (day) (year)
Cemetery or crematory Mountain View
Location Burdum Md
18. Funeral director Roy W Barber
Address Laytonsville Md
19. May 7 1946 (Date rec'd by registrar) Della V Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1946 to May 4 1946 and that I last saw h. l. M. alive on May 1 1946

Immediate cause of death	DURATION
Arteriosclerotic cardiovascular disease	35 yrs.
Due to Senility	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.
M. D. or other
Address Damascus, Md. Date signed 5/6/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4975

Reg. Dist. No. 3-16

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6706 Meadow Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: MARIE PRESCOTT McFARLAND

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John C. McFarland

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 30, 1897

8. AGE: Years	Months	Days	If less than one day
48	6	21	..... hrs. ..... min.

9. Birthplace: So. Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: Louis H. Prescott

FATHER 13. Birthplace: So. Carolina

MOTHER 14. Maiden name: Mattie Crafton

MOTHER 15. Birthplace: So. Carolina

16. Informant: Mr. John C. McFarland

Address: 6706 Meadow Lane, Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24 1946 (month) (day) (year)

Cemetery or crematory: Rock Creek Cem.

Location:

18. Funeral director: The S. H. Hines Co.

Address: 2901-14th St., N.W. Wash., D.C.

19. 5/22 1946 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1946, at 11:P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8, 1946, to May 21 1946 and that I last saw h.e.r. alive on May 20 1946

Immediate cause of death	DURATION
Carcinoma renal failure	
Due to: Malignant hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Joyce M. D. or other

Address: 546 Maple Ave. Bethesda, Md. Date signed 5-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04976

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 18 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 mons, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ala. County:

City or town: Daphne
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. #1, Box 72
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MC GILL, Alton (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10-21-25

8. AGE: Years	Months	Days	If less than one day
20	6	10	hrs. min.

9. Birthplace: Ala.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: ? McGill
13. Birthplace: unknown

MOTHER
14. Maiden name: Vashtr Yelling ?
15. Birthplace: ? unknown

16. Informant: Mo: Vashtr Yelling
Address: Rt.#1, Box 72, Daphne, Ala.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 5-1-46 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: Thomas Frazier
Address: 389 Rhode Island Avenue, N. W., Wash., D. C.

19. 5-1 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 May 19 46 at 10:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Feb 19 46 to 1 May 19 46 and that I last saw him alive on 1 May 19 46

Immediate cause of death	DURATION
Massive pulmonary hemorrhage	
Due to: Tuberculosis, pulmonary.	
Due to:	
Other conditions: Extreme emaciation.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date at:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. B. Miller D. B. MILLER, Lt. (MC) USN
M. D. or other

Address: US NH Bethesda, Md. Date signed: 5-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-10m

5/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

04977

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 days
Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W.Va. County:
City or town: Newell Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Harold Vincent MEAKIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 12, 1895

8. AGE: Years	Months	Days	If less than one day
50	8	16	hrs. min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business

FATHER
12. Name: Robert Meakin (dec)
13. Birthplace: England

MOTHER
14. Maiden name: Seling Carson (dec)
15. Birthplace: England

16. Informant: Mrs. Leonard Barlow
Address: Newell Heights, W.Va.

17. cremation (Burial, cremation, or removal. Which?) Date thereof 5-29-46 (month) (day) (year)
Cemetery or crematory:
Location: Los Angeles, Calif.
18. Funeral director: W. W. CHAMBERS Per J.B. Fee J.
Address: 1400 Chapin N.W., Georgetown, D.C.

19. 5-28 (Date rec'd by registrar) 1946 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 May 1946, at 2:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 1946, to 28 May 1946 and that I last saw him alive on 28 May 1946

Immediate cause of death	DURATION
Increased intra-cranial pressure,	
Due to Ruptured meningo-parietal branch Hemorrhage.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Increased intra cranial pressure & glioma. Date of op. 21 May 46
Autopsy results: Confirmed above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (whom?)
Means of injury: Injured at work?

23. SIGNATURE: C. S. MacCARTY, Lieut. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1054)

CERTIFICATE OF DEATH

Reg. Dist. No. 4978 212

1. PLACE OF DEATH
County: Montgomery
City or town: Hyattstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Hyattstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Carrie Thomas Miles

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Samuel P. Miles
6.(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): January-28-1870

8. AGE:

Years	Months	Days	If less than one day
76	3	7	...hrs. ...min.

9. Birthplace: Montgomery Co., Md.
(Town, county, and state)
10. Usual occupation: house-wife
11. Industry or business: home
FATHER 12. Name: Thomas McDonough
13. Birthplace: unknown
MOTHER 14. Maiden name: Rachel Keith
15. Birthplace: unknown
16. Informant: Charles William Miles
Address: 1809 Capitol View Ave., Silver Spring, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-8-46 (month) (day) (year)
Cemetery or crematory: Hyattstown Methodist
Location: Hyattstown, Md.
18. Funeral director: Wm. B. Hilton
Address: Barnesville, Md.
19. May 7 1946 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. W. B. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May - 5 1946 at 11:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1928 to May-5-1946 and that I last saw h.er alive on May - 5 - 1946

	DURATION
Immediate cause of death: Acute Bronchitis	11 days
Due to:	
Due to:	
Other conditions: Bronchiectasis —	20 or more years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William C. Miller, M.D. M. D. or other
Address: Gaithersburg, Md. Date signed: 5/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

C4979

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 hrs +

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 16 hrs +

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ~~Maryland~~ Washington County

City or town ~~Bethesda Md.~~, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1423 E Capitol St., S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clarence A. Moore

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	

B.(b) Name of ~~husband or~~ wife Mattie Moore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1889

8. AGE: Years	Months	Days	If less than one day
56 yrs	8	24	..... hrs. ..... min.

9. Birthplace Redd's Corner Maryland

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Alexander Moore

13. Birthplace Maryland

MOTHER 14. Maiden name Lillian Allen

15. Birthplace Maryland

18. Informant Bethesda Sub. Hosp.

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director W. W. Chambers Co.

Address 5717-11th St. S.E.

19. 5-17-46 (Date rec'd by registrar) 19 ..... W.E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15-46 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 14 1946 to MAY 15 1946 and that I last saw h. ~~I.M.~~ alive on MAY 15 1946

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	19 HRS
Due to HYPERTENSIVE ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE	1 YR
Due to	
Other conditions PORTAL CIRRHOSIS	YEARS

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results PORTAL CIRRHOSIS, ~~KY~~ CEREBRAL HEMORRHAGE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE DeWitt E. DeLawter M.D.

M.D. or other

Address Suburban Hosp. Bethesda, Md. Date signed May 15 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. I 04 MAY 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

C4980

Reg. Diat. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days (in Hosp)
Hospital, institution, or street address where death occurred: Washington San. & Hosp.
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 808 Greenwood Ave,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mr. Frank E. Moore

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Jessie Moore
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): June 16, 1876

8. AGE: Years	Months	Days	If less than one day
69 70	11	16	hrs. min.

9. Birthplace: Frederick, Maryland (Town, county, and state)
10. Usual occupation: Retired - Steamfitter, Plumber.
11. Industry or business:
FATHER 12. Name: Wm. H. Moore
13. Birthplace: Md.
MOTHER 14. Maiden name: Laura Virginia Hale
15. Birthplace: Md.
16. Informant: Personal Chart of deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1946 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: 3201 Bladensburg Rd. N.E.
18. Funeral director: Arthur J. Fellers
Address: 234 Carroll St. N.W. Takoma Park, D.C.
19. May 17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1946 at 8:05 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943 to May 16 1946
and that I last saw him alive on May 16 1946
Immediate cause of death: Congestive Cardiac failure — DURATION: Unknown
Due to: Cerebral Hemorrhage — 10 days
Due to: Hy. Pertension — years
Other conditions: Diabetes Mellitus — years
(Include pregnancy within 3 months of death)
Major findings of operations: X
Date of op.
Autopsy results: X
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert A. Bare M.D.
M. D. or other
Address: Takoma Park, Md. Date signed: 5/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (546)

CERTIFICATE OF DEATH

C4981

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Berkeley

City or town: RURAL, Hedgesville West Va.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 2
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MYERS, Walter Benjamin, Veterans Bureau Patient

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Married

6.(b) Name of husband or wife: Aranka C. Myers

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 3, 1895

8. AGE: Years	Months	Days	If less than one day
51	3	8	..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Labor Foreman

11. Industry or business:

FATHER
12. Name: William Myers
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Emma Hatfield
15. Birthplace: West Virginia

16. Informant: Wife: Mrs. Aranka C. Myers
Address: Route # 2, Hedgesville, West Va.

17. ~~Burial~~ Removal Date thereof: May 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Rosedale Cemetery

Location: Martinsburg, West Virginia

18. Funeral director: W. W. Chambers by J R W

Address: 3072 M St. N.W., Wash. D.C.

19. 5-13-46 19..... Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 May 1946, at 1253 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 May 1946 to 11 May 1946 and that I last saw him alive on 11 May 1946

Immediate cause of death: Brain tumor (Glioma, Brain) — DURATION: 6 mo. +

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operation: Large, inoperable, malignant brain tumor. Date of op. 5/4/46

Autopsy results: Tumor, brain, right hemisphere

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. K. Kloos
E. K. KLOOS, Lt. (jg) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

04982

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R # 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Sarah L. Nicholson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife John R. Nicholson.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 18, 1879

8. AGE: Years	Months	Days	If less than one day
66	9	12	..... hrs. ..... min.

9. Birthplace Ashton, Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name John W. Lucas

13. Birthplace Virginia

MOTHER 14. Maiden name Alice Ella Johnson

15. Birthplace Ashton, Maryland.

16. Informant Hospital record.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2 1946 (month) (day) (year)

Cemetery or crematory Damestown Md.

Location

18. Funeral director Wm R. Dunnigan

Address Bethesda Md.

19. June 1 1946 (Date rec'd by registrar) Gertrude B. Lawton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1946, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1946 to May 30 1946 and that I last saw h.e alive on May 30 1946

	DURATION
Immediate cause of death Bilateral Pyelo-nephritis Acute	3 mos.
Due to appendicitis.	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Acute appendicitis.

Date of op. 5/29/46

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

04983

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? died on admission

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 17th St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: OSER, Anna Mary

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Mr. Joseph Oser

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 14 April 1891

8. AGE: Years	Months	Days	If less than one day
55	1	16	hrs. min.

8. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: F. A. O'Brien
13. Birthplace: Wash., D.C.

MOTHER
14. Maiden name: ?
15. Birthplace: Wash., D.C.

16. Informant: husband: Mr. Joseph Oser
Address: 202 17th St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5-21-46 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Francis Gasch's & Sons

Address: 4739 Baltimore Avenue, Hyattsville, Md.

19. 5-18 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 May 19 46, at 11:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 May 19 46, to 18 May 19 46 and that I last saw h er alive on 18 May 19 46

Immediate cause of death	DURATION
Coronary Thrombosis with	
myocardial infarction	
Due to: Arteriosclerosis of	
coronary arteries	
Due to:	
Other conditions: Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. B. Ford
W. B. FORD, Lt. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

6/7/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

State File No. 4984 Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Beallsville - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Not at all

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Beallsville - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 yds North Rt 28 on Rd to Barnesville

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl Owens

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	Colored	Single.

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 16 - 1946

8. AGE: Years | Months | Days | If less than one day: 2 hrs. 0 min.

9. Birthplace Beallsville

(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER

12. Name Charles Edward Owens

13. Birthplace Beallsville, Md

MOTHER

14. Maiden name Annie Elizabeth Moore

15. Birthplace Poolesville, Md

16. Informant Annie Elizabeth Owens

Address Beallsville, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-20-46 (month) (day) (year)

Cemetery or crematory own property

Location Beallsville, Md. R.F.D.

18. Funeral director Wm. B. Hilton

Address Barnesville, Md.

19. May 19 1946 (Date rec'd by registrar) Mrs. C. C. Hilton Reg. Mrs. Co. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1946, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1946, to May 16 1946 and that I last saw h.r. alive on May 16 1946

Immediate cause of death	DURATION
Prematurity (6 Months)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert K. John MD M. D. or other

Address Poolesville, MD Date signed May 17, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

04985

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? — 2 hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? — 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 141 35th St., N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Baby Girl Pendleton #1

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	—

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 30, 1946

8. AGE: Years	Months	Days	If less than one day
—	—	—	2 hrs. — min.

9. Birthplace Takoma Park, Montgomery, Maryland (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name Edmund Elliott Pendleton

13. Birthplace Chicago, Illinois

MOTHER

14. Maiden name Ethel Dean Morse

15. Birthplace Lakeland, Florida

16. Informant Records - Washington Sanitarium and Hospital

Address 700 Carroll Avenue, Takoma Park, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 31-1946 (month) (day) (year)

Cemetery or crematory Washington Sanitarium Hospital

Location Takoma Park, Md

Md. Record Library

18. Funeral director Rose Freeman K.R.L.

Address Washington Sanitarium + Hosp

(written consent of parents)

19. May 31 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 30 - 1946, at 2 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw her alive on 5 - 30 - 1946

Immediate cause of death Prematurity — 5½ mos. gestation

Due to Twin pregnancy

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D. M. D. or other

Address Takoma Park, Md. Date signed 5-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

04988

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? — 2 hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? — 2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 141 35th St, N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Baby Girl Pendleton #2

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	—

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 30, 1946

8. AGE:

Years	Months	Days	If less than one day
—	—	—	2 hrs. 0 min.

9. Birthplace Takoma Park, Montgomery, Maryland (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name Edmund Elliott Pendleton

13. Birthplace Chicago, Illinois

MOTHER

14. Maiden name Ethel Dean Morse

15. Birthplace Lakeland, Florida

16. Informant Records - Washington Sanitarium and Hospital

Address 700 Carroll Avenue, Takoma Park, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 31-1946 (month) (day) (year)

Cemetery or crematory Washington Sanitarium Hospital

Location Takoma Park, Md.

18. ~~Funeral director~~ Rose Freeman, R.R.C.

Address Washington Sanitarium Hospital

Written consent Parents

19. May 31 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1946, at 2:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw her alive on 5-30- 1946

Immediate cause of death prematurity

5½ mo gestation

Due to Twin pregnancy

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Emma Hughes M.D. M. D. or other

Address Takoma Park, Md. Date signed 5-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

med. Record Library

Evidence for the change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

File No. 104 JUN - 6 1946

C4987 216

Reg. Dist. No.

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Okla. County:

City or town: Stillwater

(If outside city or town limits, write RURAL and give nearest town)

Street No. 312½ West Maple St.,

(If rural give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: PHILLIPS, Paul Duane, Lt. (C) USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Elizabeth M. Phillips

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1-12-19

8. AGE: Years	Months	Days	If less than one day
27 28	4	4	hrs. min.

9. Birthplace: California (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER — 12. Name: Percy H. Phillips

FATHER — 13. Birthplace: Ill.

MOTHER — 14. Maiden name: Emily Kessler,

MOTHER — 15. Birthplace: Calif.

16. Informant: wife: Mrs. Elizabeth M. Phillips

Address: 312½ West Maple St., Stillwater, Okla.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-20-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Geo. W. Wise, [illegible]

Address: 2900 M St., N. W., Wash., D.C.

19. 5-16 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 May 1946 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 May 1946 to 16 May 1946 and that I last saw h[illegible] im alive on 16 May 1946

Immediate cause of death	DURATION
ulcerative colitis	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. L. Fleck R. L. FLECK, Lt.(jg) (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

5/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

C4988

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 26days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County:

City or town: Erie
(If outside city or town limits, write RURAL and give nearest town)

Street No. 210 8th St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: PICKLESIMER, Newton (none) VAP

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 2, 1884

8. AGE: Years	Months	Days	If less than one day
61	6	28	hrs. min.

9. Birthplace: Kentucky (Town, county, and state)

10. Usual occupation: veteran

11. Industry or business

FATHER — 12. Name: B. F. Picklesimer

13. Birthplace: Kentucky

MOTHER — 14. Maiden name: Elisa Pelphrey

15. Birthplace: Kentucky

16. Informant: Son: Newton D. Picklesimer

Address: 210 8th St., Erie, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-1-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: W. W. CHAMBERS

Address: 3072 M St., NW, Washington, D.C.

19. 30 May 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 May 1946, at 9:45a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4 March 1946, to 30 May 1946 and that I last saw him alive on 30 May 1946

	DURATION
Immediate cause of death: Bronchopneumonia	
Due to: Rheumatoid Arthritis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. H. C. SMITH, Comdr. (MC) USNR
M. D. or other

Address: US NH Bethesda, Md. Date signed: 6-3-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04989

Reg. Dist. No. 2-16

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 6 days - 93 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.R. #1 Rockville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Beatrice Thomas Pineo

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Victor Pineo
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 16, 1909.

8. AGE: Years	Months	Days	If less than one day
37	0	29	hrs. min.

9. Birthplace: Canada (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: R.N.
FATHER 12. Name: John Thomas
FATHER 13. Birthplace: New Brunswick - Canada
MOTHER 14. Maiden name: Lillie Evans
MOTHER 15. Birthplace: New Brunswick - Canada
16. Informant: Mr Victor Pineo
Address: R.F.D. #1 Rockville, Md.
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 5/14/46 (month) (day) (year)
Cemetery or crematory: Fredericton, New Brunswick CANADA
Location: Canada
18. Funeral director: Wm Reuben Dunphreys
Address: Bethesda, Maryland
19. 5/13/46 (Date rec'd by registrar) Wm F Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1946, at 3:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 (Exam Case) 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
1st 2nd and 3rd degree burns involving 60% of body and extremities	6 days
Due to	
auto accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 5-3-46
Where did injury occur? Rockville (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto accident Injured at work? No

23. SIGNATURE: Frank J. Bouchat M.D. M. D. or other
Address: Gaithersburg Md Date signed 5-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-A)

CERTIFICATE OF DEATH

★ 94990

Reg. Diat. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Five Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersville Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Poole

3.(b) Social Security Number V

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Melvin D. Poole
6.(c) If alive, give age 58 years
7. Birth date of deceased (mo., day, yr.) April 12 - 1889

8. AGE: Years	Months	Days	If less than one day
57	1	19	....hrs. ....min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Home Wife
11. Industry or business Home
FATHER 12. Name Basil Glaze
13. Birthplace Montgomery Co Md
MOTHER 14. Maiden name Mary E Lewis
15. Birthplace Montgomery Co Md
16. Informant Melvin D. Poole
Address Monrovia Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jun 3 1946 (month) (day) (year)
Cemetery or crematory Montgomery Church
Location Gaithersville Md
18. Funeral director Roy W Barber
Address Laytonsville Md
19. June 1 1946 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1946 at 12:00 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to Med Exam Case 19
and that I last saw h... alive on ... 19

Immediate cause of death	DURATION
(a) Uraemia Poisoning	14 hrs
Due to (b) (Suicide)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide suicide Date of 5-31-46
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Injured at work?

23. SIGNATURE Frank J. Bosshart M.D.
Dec Med Exam
M. D. or other
Address Gaithersburg Md Date signed 5-31-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4391

★ Reg. Diat. No. 2, 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 days 3 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Prather

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	child

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 1946.

8. AGE: Years | Months: 5 | Days | If less than one day: hrs. min.

9. Birthplace: Montgomery Co. Md. (town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: ?

13. Birthplace

MOTHER 14. Maiden name: Mary Prather

15. Birthplace: Md.

16. Informant: E. Gertrude Prather (aunt)
Address: Gaithersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27, 1946 (month) (day) (year)
Cemetery or crematory: Poolesville Church. Cem.
Location: Poolesville, Md.

18. Funeral director: R. L. Snowden
Address: Rockville, Md.

19. 5/27/1946 (Date rec'd by registrar) Wm E Jabes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 1946 at 6 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 1946, to May 24 1946 and that I last saw h. I.M. alive on May 24 1946

Immediate cause of death	DURATION
Acute ENTERITIS	15 days
Due to	
Due to	
Other conditions: severe MALNUTRITION	UNKNOWN

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: DeWitt E. DeFuster M.D. M. D. or other
Address: Suburban Hosp. Bethesda, Md Date signed May 25 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04992

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase-15
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4014 Oliver Street
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME MRS. GENE BURGESS PRENTISS

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife Roger G. Prentiss
6.(c) If alive, give age Deceased years
7. Birth date of deceased (mo., day, yr.) February 24, 1881

8. AGE: Years	Months	Days	If less than one day
65	3	5	..... hrs. ..... min.

9. Birthplace Johnson, Vermont (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name Banum L. Austin
13. Birthplace Johnson, Vermont
MOTHER 14. Maiden name Nellie Burgess
15. Birthplace Enosburg Fall, Vermont
16. Informant Roger G. Prentiss, Jr.
Address 4014 Oliver St., Chevy Chase, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)
Cemetery or crematory
Location Johnson, Vermont
18. Funeral director W. Reuben Thompkins
Address Bethesda, Maryland
19. 5/29 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1946 at 6:30 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1946 to May 29 1946
and that I last saw her alive on May 29 1946

	DURATION
Immediate cause of death Acute myocardial failure	3 days
Due to Chronic myocarditis	3 mos.
Due to Generalized arterio-sclerosis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George Dewey M. D. or Other
Address 4331 Forest Lane, N.W. Washington, D.C. Date signed 5/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

64993

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 21 Elm Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: EMORY F. C. (CRIT) RAY

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Ellen Ray

6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): October 22, 1860

8. AGE: Years: 85 Months: 6 Days: 23 If less than one day: hrs. min.

9. Birthplace: Rockville, Maryland (Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business:

FATHER

12. Name: William Henry Ray

13. Birthplace: Maryland

MOTHER

14. Maiden name: Virginia D. Ward

15. Birthplace: Maryland

16. Informant: Henry Gorman Ray

Address: 21 Elm Ave., Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18, 1946 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: W. Reuben Saunders

Address: Bethesda, Maryland

19. May 16 1946 (Date rec'd by registrar) J. Holmes Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15th 1946, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to May 15th 1946

and that I last saw h[illegible] alive on May 7 1946

Immediate cause of death: Coronary Thrombosis — DURATION: Sudden

Due to:

Due to:

Other conditions: Hypertension

Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Harrison Beardwood M.D. M. D. or other

Address: 9601 Sutton Pl. Silver Spring, Md. Date signed: 5/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

04994

Reg. Dist. No. 7-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural, near Silver Spring
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Cedarcroft Sanitorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 130 Hilltop Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CATHERINE ADELINE RAYER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband ~~or wife~~: Robert E. Rayer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1869

8. AGE: Years	Months	Days	If less than one day
76	11	0	hrs. min.

9. Birthplace: Arcadia, Indiana (Town, county, and state)

10. Usual occupation: Housewife, retired

11. Industry or business: Own home

FATHER 12. Name: Joseph Knause

FATHER 13. Birthplace: Pa.

MOTHER 14. Maiden name: Mary Goldman

MOTHER 15. Birthplace: Ohio

16. Informant: Mrs Irene R. Denison

Address: 130 Hilltop Road, Silver Spring, Md.

17. Shipment & burial (Burial, cremation, or removal. Which?) Date thereof: May 19, 1946 (month) (day) (year)

Cemetery or crematory: Crown Point Cemetery

Location: Kokomo, Howard Co., Indiana

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. May 18 1946 (Date recd by registrar) Josephine M. Schaffle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1946 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1946, to May 16 1946

and that I last saw h~~er~~ alive on May 16 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2 days.
Due to: Fracture of Lft Femur	Feb 19
Due to:	
Other conditions: Senile Psychosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: fracture surgical neck left femur Date of op.: Feb. 21-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 2-19-46

Where did injury occur? Cedercroft Sanitorium (City or town) Montgomery (County) Md. (State)
Silver Spring, Md

Injured at home, farm, industry, public place (where?) Cedarcroft Sanitarium

Means of injury: Fall — Injured at work? —

23. SIGNATURE: A. W. Mitchell, M. D. M. D. or other

Address: Silver Spring, Md. Date signed: 5-19-46

Evidence for change of age of deceased is shown on FILM No. I 0 4 MAY 15 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-E)

CERTIFICATE OF DEATH

04995 Reg. Dist. No. 2/3-

1. PLACE OF DEATH:
County Montgomery
City or town R.F.D. 3 Gaithersburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town R.F.D. #3 Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 28 - 2 miles S. E. Darnestown
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Ernest H. Rich
3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	Widowed

6.(b) Name of husband or wife Emma Rich
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 8. 1874

8. AGE: Years 71 | Months 7 - 2 - 8 | Days 19 | If less than one day — hrs. — min.

9. Birthplace R.F.D. #3. Gaithersburg Md
(Town, county, and state)

10. Usual occupation Day laborer on farm.
11. Industry or business Farming

FATHER
12. Name James Rich
13. Birthplace Montg. Co. Md.

MOTHER
14. Maiden name Martha Gilt
15. Birthplace Monta. Co. Md

16. Informant Thompson Rich
Address 69 Seaton Place N. W.

17. Burial Date thereof 5-7-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Dunce Orchard Md
Location Colored Church Dunce Orchard
18. Funeral director Robert L. Snowden
Address Rockville Md.

19. 5/7-46 Josephine D. Mullen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2nd 1946, to May 4th 1946
and that I last saw him alive on May 3rd 1946

Immediate cause of death: Acute Myocarditis — DURATION 10 da.
Due to Uraemia from chronic prostatitis
Due to Urinary Obstruction
Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Upton D. Towse M.D.
M.D. or other
Address Darnestown-Boyds Md Date signed 5-4-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

04996

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Garrett Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mo.
Hospital, Institution, or street address where death occurred:
Georgetown Preparatory School
How long in Hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Garrett Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles W. Riley S.J.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 19 1919

8. AGE: Years: 26 | Months: 11 | Days: 26 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: teaching

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: "
15. Birthplace

16. Informant: Georgetown Preparatory School
Address: Garrett Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/20/46 (month) (day) (year)
Cemetery or crematory: Georgetown Coll. Cem.
Location: Wash. D.C.

18. Funeral director: Timothy Manlon
Address: 641 N St. N.E. Wash DC

19. 5/17 19.46 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 19.46 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. med. Exam case 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death	Found dead in bathroom.
Due to: Asphyxia	
Due to: Hanging (suicide)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of 5-11-46
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D. Sep. med. Exam. M. D. or other
Address: Gaithersburg Md Date signed 5-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-d)

CERTIFICATE OF DEATH

04997

Reg. Dist. No. 514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 7-8 mo.
Hospital, institution, or street address where death occurred:
9 Pearson St.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rural - Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Burnt Mills
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frank Williams Ritter

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 1, 1866

8. AGE: Years: 80 | Months: 4 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Washington D. C.
(Town, county, and state)

10. Usual occupation: Retired.

11. Industry or business

MOTHER FATHER
12. Name: William Henry Ritter
13. Birthplace: Washington D. C.

MOTHER
14. Maiden name: Maria Christina Diggs
15. Birthplace: Philadelphia, Penna.

16. Informant: Mrs. R. E. Sexton
Address: 3026 Porter St. N. W. Washington D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1946 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery
Location: Washington, D.C.

18. Funeral director: Joseph F. Birch & Sons
Address: 3034-M St. N.W. - Wash., D.C.

19. May 26 1946 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1946, at 6:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-31 1945 to May 26 1946 and that I last saw h— alive on May 20 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden
Due to: Hypertensive Heart Disease	
Due to:	
Other conditions: Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Marion Bamberger M.D.
M. D. or other
Address: Silver Spring, Md. Date signed: 5/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (196-a)

CERTIFICATE OF DEATH

★ 04998

Reg. Diat. No. 213

1. PLACE OF DEATH:
County: Moulgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
301 - 1st
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Moulgomery
City or town: Rockville
(If outside city or town limits, write RURAL and giva nearest town)
Street No.: 301 1st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alice Ann Roberson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel L. Roberson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 16 1858

8. AGE: Years 87 | Months 10 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace: Derwood - Moulg Co Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Robert Nicholls
13. Birthplace: Derwood - Maryland

MOTHER
14. Maiden name: Mary Nicholson
15. Birthplace: Moulg Co - Maryland

16. Informant: Mrs. Ruby Morningstar
Address: 301 - 1st Rockville Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: May 26 1946
(month) (day) (year)
Cemetery or crematory: Rockville Union Cem
Location: Near Rockville - Moulg Co.

18. Funeral director: Wm. Reuben Timanus
Address: Rockville - Maryland

19. 5/25/46 Josephine D. Poston
(Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1946 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1946, to May 23 1946.
and that I last saw h alive on May 23 1946.

	OURATION
Immediate cause of death: Fracture of surgical femur	April 11 46
Due to: Myocardial failure	10 days
Due to: Senility	
Due to: Accidental falls in kitchens of	
Other conditions: her own homes. Q.W.S.R.	

(Include pregnancy within 3 months of death)

Major findings of operations: Cast applied to leg April 18 46
Date of op
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of April 11th 1946
Where did injury occur? Rockville (City or town) Montgomery (County) Maryland (State)
Injured at home, farm, industry, public place (where?): At home
Means of injury: Accidental falls Injured at work?

23. SIGNATURE: Wm. G. Smithson M.D.
M. D. or other
Address: Rockville Md Date signed 5/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

C4999

★ Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rural Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. xxxx "Prevention Oak", Halpine Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war -----

3.(a) FULL NAME EDNA H. ROTH

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband xxx Edward J. Roth
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1882

8. AGE: Years	Months	Days	If less than one day
64	4	8	..... hrs. ..... min.

9. Birthplace Lincoln, Nebraska (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name J. H. Harley
13. Birthplace Nova Scotia

MOTHER
14. Maiden name Adele Howell
15. Birthplace Illinois

16. Informant Edward J. Roth
Address Halpine Rd., Rockville, Md.

17. Transportation & burial (Burial, cremation, or removal. Which?) Date thereof May 27, 1946 (month) (day) (year)
Cemetery xxxxx Wyuka Cemetery
Location Lincoln, Lancaster Co., Neb.

18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.

19. 5/27 1946 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24/ May/1946 at 11-10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept/1943 19.. to 24/ May 1946 and that I last saw h.. alive on 24/ May/1946

Immediate cause of death	DURATION
Myocardeal Infarction	
Due to Coronary Artery Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles R. L Hally MD M.D. or other
Address 1801 Eye St N.W Washington D.C. Date signed 25/ May 46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

05060

Reg. Dist. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
10,620 So. Dunmoor Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 10,620 So. Dunmoor Drive
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: ISAAC REYNOLDS RUCKER

3. (b) Social Security Number: 225-03-4665

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Theresa Lawless Rucker

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 20th. 1876

8. AGE: Years	Months	Days	If less than one day
70	1	27	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: James Rucker

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Lavinia Cox

MOTHER — 15. Birthplace: Virginia

16. Informant: Mrs. Joseph Downs.

Address: 10620 S. Dunmoor Dr. Silver Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-20-1946 (month) (day) (year)

Cemetery or crematory: St. Mary's

Location: Rockville, Montg. Co. Md.

18. Funeral director: Wayne E. Pumphrey

Address: Silver Spring, Md.

19. May 19 1946 (Date rec'd by registrar) Josephine McKnight Registrar

MEDICAL CERTIFICATION

3:10 P.

20. DATE OF DEATH: May 17 1946, at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. med. exam case, 19.. to ..... 19.. and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Cerebral hemorrhage	1/2 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bronhart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg md. Date signed: 5-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05001 Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 59 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1329 16th St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Schippell, Mr. Edward J.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Theresa M. Schippell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 27, 1868

8. AGE: Years: 78 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Theodor J. Schippell

13. Birthplace: Germany

MOTHER — 14. Maiden name: Unk.

15. Birthplace: Germany

16. Informant:

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17, 1946 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Suitland, Md.

18. Funeral director: The J. F. Sinnes Co.

Address: 2901 14th St. N.W.

19. May 13 1946 (Date rec'd by registrar) J. Holmes Reed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1946 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1946 to May 13 1946

and that I last saw him alive on May 13 1946

Immediate cause of death	DURATION
Carcinoma Stomach	6 months
Due to:	
Due to:	
Other conditions: Ruptured Stomach	

(Include pregnancy within 3 months of death)

Major findings of operations: as above Date of op.: 3/15/46

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John H. Broumsheger, M.D. M. D. or other

Address: Takoma Park Date signed: 5-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C5602

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred: Jolliffe Nursing Home

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Virginia County:

City or town: 1733 Queens Lane (If outside city or town limits, write RURAL and give nearest town)

Street No. Arlington (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Bell Shaw

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frederick B. Shaw

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 3, 1879

8. AGE: Years	Months	Days	If less than one day
66	9	28	hrs. min.

9. Birthplace: Helena, Montana (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Joseph Davis

FATHER — 13. Birthplace: Chester, Penna.

MOTHER — 14. Maiden name: Flora Marsh

MOTHER — 15. Birthplace: Jeffersonville, Ind.

16. Informant: Jessie P. Jolliffe

Address: 805 Maple Avenue, Takoma Park, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 2, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, Md.

18. Funeral director: Birch Funeral Home

Address: 3034 M St. N.W. Wash. D.C.

19. May 1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1946, at 1:01 P.M. Staff of Walter Reed Hosp

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1934, to May 1, 1946 and that I last saw her alive on 30 April 1946

Immediate cause of death	DURATION
Adenocarcinoma of breast with metastasis, generalized	1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Mastectomy, left, radical. Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Kirk Moore 1st Lt. M.C. M. D. or other

Out Patient Service

Address: Walter Reed General Hosp. Wash., 12, D.C. Date signed: 5/1/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-0) +

CERTIFICATE OF DEATH

05603

★ Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery

City or town Damascus Md

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? All Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infnnts give residence of mother)

State Maryland County Montgomery

City or town Damascus

(If outside city or town limits, write RURAL nnd give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Edith May Sheckels

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Nathan Sheckels

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1871

8. AGE: Years	Months	Days	If less than one day
74	7	22	....hrs. ....min.

9. Birthplace Montgomery Co Md (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

FATHER 12. Name Eliza M. J. Bowers

FATHER 13. Birthplace

MOTHER 14. Maiden name Eliza M Ferris

MOTHER 15. Birthplace Montgomery Co Md

16. Informant Rena Carter

Address Mouroia

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2, 1946 (month) (day) (year)

Cemetery or crematory Damascus Md

Location Montgomery Co Md

18. Funeral director Roy W. Barlow

Address Laytonsville Md

19. June 1, 1946 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1946, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 1944, to May 29, 1946, and that I last saw h E.R. alive on May 19....

Immediate cause of death Bronchogenic Carcinoma Right Lung Generalized Metastasis — DURATION 1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury Injured at work?

23. SIGNATURE James F. Kerr M.D. M. D. or other

Address Damascus, Md. Date signed 5/31/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

C5664

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County Montgomery
City or town R.F.D #1 Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town R.F.D #1 Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME John Edward Sinclair

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Nannie Mae Sinclair
6.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) Sept. 20, 1864

8. AGE:

Years	Months	Days	If less than one day
81	7	18	... hrs. ... min.

9. Birthplace Washington D. C.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Richard Sinclair
13. Birthplace Virginia
MOTHER 14. Maiden name —
15. Birthplace —
16. Informant Mrs. Nannie Mae Sinclair
Address R.F.D #1 Silver Spring Md
17. Oak Hill (Burial, cremation, or removal, which?) Date thereof 5 10 1946 (month) (day) (year)
Cemetery or crematory Oak Hill Cemetery
Location Wash. D.C.
18. Funeral director Saffell
Address 4758 N. Y. Ave.
19. May 8 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1946, at 7:25 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1946, to May 8 1946
and that I last saw him alive on May 8 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions Hypertension Heart Disease	—

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE J. Marion Bamford M.D. M. D. or other
Address 9691 Dutton St. Silver Spring Md Date signed 5/8/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05605

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Monty.
City or town: WESTMORELAND Hills MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: Monty.
City or town: WESTMORELAND Hills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: #8 BLACKISTONE RD.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BAIRD SNYDER III

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	MARRIED

6.(b) Name of husband or wife: BEATRICE S SNYDER
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): AUGUST 17 1899

8. AGE: Years: 46 Months: Days: If less than one day: hrs. min.

9. Birthplace: LANSFORD PENN.
(Town, county, and state)

10. Usual occupation: FEDERAL WORK ASST

11. Industry or business: ADMINISTRATOR

FATHER
12. Name: BAIRD SNYDER II
13. Birthplace: PENN.

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace:

16. Informant: MRS BAIRD SNYDER
Address: 8 BLACKISTONE RD MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/21/46 (month) (day) (year)
Cemetery or crematory: POTOMAC PENN.
Location: POTOMAC PENN

18. Funeral director: Joseph Gawler Sons
Address: 1756 Pa. Ave. N.W. Wash. D.C

19. 5/21 19 46 (Date rec'd by registrar) Wm E Jales Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 18th 1946, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1934 19 to MAY 18th 1946
and that I last saw him alive on MAY 18th 1946

	DURATION
Immediate cause of death: Coronary Occlusion	1/2 hour
Due to: Coronary Sclerosis	?
Due to:	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W B Sims. M. D. or other
Address: 1746 K St. N.W. Date signed: 5/21/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-a)

CERTIFICATE OF DEATH

★ C5666 Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

5/22/46

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 712 Bailey Place, S. E. Apt. #2
(If rural, give LOCATION)

2.(a) If veteran, name war: ★

3.(a) FULL NAME

Scott Preston SQUYRES V.B.P.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
ml	W-US	married

6.(b) Name of husband or wife: Mary L. Squyres

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1 1895

8. AGE: Years	Months	Days	If less than one day
50	10	16	hrs. min.

9. Birthplace: Okla. (Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business

FATHER
12. Name: Dallas Rayburn
13. Birthplace: unknown

MOTHER
14. Maiden name: Fannie London
15. Birthplace: Ark.

16. Informant: Mrs. Mary L. Squyres

Address: 712 Bailey Pl. S.E. Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof May 19, 1946 (month) (day) (year)

Cemetery or crematory: Memorial Park

Location: Oklahoma City, Okla.

18. Funeral director: W.W. Chambers Co. CB

Address: 1400 Chapin St., N. W., Wash., D. C.

19. May 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 May 1946 (M) at 10:40 pm

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 24 April 19 46 to 17 May 19 46 and that I last saw h im alive on 17 May 19 46

	DURATION
Immediate cause of death: Cerebral hemorrhage	3 days
Due to: Hypertension	10 yrs ?
Due to: Chronic nephritis	20 yrs ?
Other conditions: generalized arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Cerely. hemorr. Bright's disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C W Thompson C. W. THOMPSON, Lt. Comdr. (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47(c)

CERTIFICATE OF DEATH

05607

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 6 days - 21 hrs +

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7814 Custer Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Alfred H. Steel

3.(b) Social Security Number 213-14-5636

4. Sex	5. Color or race	6. Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Eleanor Steel (Deceased)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 17, 1881

8. AGE: Years	Months	Days	If less than one day
65	1	20	..... hrs. ..... min.

9. Birthplace N. York (Town, county, and state)

10. Usual occupation Justice of Peace - Clerk

11. Industry or business Montgomery County Police

FATHER 12. Name John H. Steel

13. Birthplace N. York

MOTHER 14. Maiden name Kathryn Cromwell

15. Birthplace N. York

16. Informant Miss Ruth French

Address 9 Wilson Lane, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 1946 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Washington D.C.

18. Funeral director Wm. Rawlings Pumphrey

Address Bethesda, Md.

19. 5/8 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1946, at 1:43 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946, to May 7 1946

and that I last saw h. alive on May 7 1946

Immediate cause of death	DURATION
BRONCHIOGENIC CARCINOMA OF LEFT LUNG	UNKNOWN
Due to	
Due to	
Other conditions THROMBOSIS OF LT. CORONARY ARTERY (Include pregnancy within 3 months of death)	UNKNOWN

Major findings of operations ..... Date of op. .....

Autopsy results BRONCHIOGENIC CARCINOMA LT. LUNG

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Emil G. Bauersfeld M. D. or other

Address Bethesda, Md. Date signed 5/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 15668

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 204 Willow Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Stone, Charles Leon

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: May Pines Stone

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1871

8. AGE:

Years	Months	Days	If less than one day
74	5	2	..... hrs. ..... min.

9. Birthplace: Plymouth, Ind.
(Town, county, and state)

10. Usual occupation: Minister of the Gospel

11. Industry or business: Church.

FATHER
12. Name: J. Stone
13. Birthplace: Ft. Recovery, Ohio.

MOTHER
14. Maiden name: Ruth Martindale.
15. Birthplace: Peru, Ind.

16. Informant: Wife

Address: 204 Willow Ave. Takoma Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27, 1946 (month) (day) (year)

Cemetery or crematory: Geo. Wash. Memorial Cemetery

Location: Riggs Rd. Hyattsville, Md.

18. Funeral director: J. Arthur Walters

Address: 25 Carroll St. Takoma Park, D.C.

19. May 24 1946 (Date rec'd by registrar) J. D. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1946, at 11 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to May 23 1946 and that I last saw him alive on May 23 1946

Immediate cause of death	DURATION
Coronary Occlusion	1 minute
Due to: Arteriosclerosis	years
Due to: Hypertension	years
Other conditions: Tuberculosis-old.	years

No evidences of an active state in recent years
(Include pregnancy within 3 months of death) C.W.S.R.

Major findings of operations:

Date of op.:

Autopsy results: X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert A Hare MD. (M. D. or other)

Address: Takoma Park Md. Date signed: 5/24/46

Evidence for change of age of deceased is shown on

05009

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

FILM No. I 04 MAY 31 1946

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 24 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: NY County:
City or town: New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 87 Barrett St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: STOUT, Lewis Napoleon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-2-97

8. AGE: Years	Months	Days	If less than one day
48 ~~49~~	6	13	hrs. min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business:

FATHER
12. Name: William Stout
13. Birthplace: Va.

MOTHER
14. Maiden name: Lucy McGuffy
15. Birthplace: Va.

16. Informant: Mo: Mrs. Lucy Stout,
Address: 87 Barrett St., N.Y., N.Y.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5-18-46 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.
18. Funeral director: W. W. CHAMBERS
Address: Georgetown, D. C.

19. 5-15 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 May 1946 at 8:25A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Feb. 1946 to 15 May 1946 and that I last saw him alive on 15 May 1946

Immediate cause of death	DURATION
Congestive heart failure	6 mos.
Due to Hypertension	years
Due to arteriosclerosis and Chronic nephritis.	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Chronic nephritis & gen. arteriosclerosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

22. SIGNATURE: C. W. THOMPSON, Lt.Cdr.(MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 5-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

5/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93e)

CERTIFICATE OF DEATH

05610

Reg. Diat. No. 244

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
9213 Saybrook Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9213 Saybrook Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARY ELIZABETH STUPP

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~xxx~~ Randolph J. Stupp
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6, 1861

8. AGE: Years	Months	Days	If less than one day
84	11	10	..... hrs. ..... min.

9. Birthplace Funkstown, Md. (Town, county, and state)
10. Usual occupation Retired Housewife
11. Industry or business Own Home
FATHER 12. Name Edward Flynn
13. Birthplace Md.
MOTHER 14. Maiden name Sarah De Show
15. Birthplace Pa.
16. Informant Mrs. Albert J. George
Address 9213 Saybrook Ave., Silver Spring, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20, 1946 (month) (day) (year)
Cemetery or crematory Cedar Hill Cryptorium
Location Suitland Rd., Pr. Geo. Co., Md.
18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.
19. May 17 1946 (Date rec'd by registrar) Josephine M. Shaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 MAY 1946 at 10:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 MAY, 1946, to 16 MAY 1946 and that I last saw h.R.T. alive on 16 MAY, 1946

Immediate cause of death	DURATION
TERMINAL PNEUMONIA	
Due to CONGESTIVE HEART FAILURE	
Due to ARTERIOSCLEROSIS, GENERALIZED, SEVERE	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations NONE Date of op. —
Autopsy results NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. Marshall Leuwilling Jr. M.D.
M.D. or other
Address 8648 Georgia Ave Silver Spring, Md. Date signed 16 May, 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

05011

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery.

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7619 Delwood Pl.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Nelson Vance

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Pearl D. Carr

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Jan. 17. 1870

8. AGE: Years 76 Months 4 Days 1 If less than one day ... hrs. ... min.

9. Birthplace Brown County Ohio (Town, county, and state)

10. Usual occupation Builder

11. Industry or business own.

FATHER

12. Name William Skyler Vance

13. Birthplace Adams Co. Ohio.

MOTHER

14. Maiden name Mary Elizabeth Davis.

15. Birthplace Adams Co. Ohio.

16. Informant Henry S. Vance

Address 7619 Delwood. Pl. Bethesda

17. Burial Date thereof Jan. 20 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Wash. D.C.

18. Funeral director The S. H. Hines Co.

Address 2901 14th St. N.W.

19. 5/18 1946 Wm E. Jobes

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH - May - 18 1946 at 9 - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945, to May 1946,

and that I last saw h[im] alive on May 16 1946

Immediate cause of death: Circulatory Collapse

DURATION

Due to: Influenza —

Due to:

Other conditions: Generalized Arteriosclerosis Amputation of left leg.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE F. A. Martinez M. D. or other

Address 4648 Cathedral Ave Date signed May 18/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(5) 12

Reg. Dist. No. 213.

1. PLACE OF DEATH:

County Montgomery

City or town R.F.D. Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD, Hunting Hill

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leonid N. Vassilieff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ludmilla

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 21, 1888

8. AGE: Years	Months	Days	If less than one day
57	11	20	...hrs. ...min.

9. Birthplace St. Petersburg, Russia

(Town, county, and state)

10. Usual occupation Navy Dept. Bureau of Ships

11. Industry or business

FATHER 12. Name Nicholas Vassilieff

13. Birthplace Russia

MOTHER 14. Maiden name Mary —

15. Birthplace Russia

16. Informant Mrs. Ludmilla Vassilieff

Address RFD Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/13/46 (month) (day) (year)

Cemetery or crematory Rockville Union Cem.

Location Rockville, Maryland

18. Funeral director Wm Reuben Humphrey

Address Rockville Md.

19. 5/12/46 (Date rec'd by registrar) Josephine D. Hoxton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 19 46 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. Med. Exam 19 to case 19

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchat M. D. Med. Exam, M. D. or other

Address Gaithersburg Md. Date signed 5-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

(5013)

Reg. Dist. No. 216

1. PLACE OF DEATH

County Montgomery Co.

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
5418 McKinley St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5418 McKinley St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William M. M. Wailes Sr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed.

6.(b) Name of husband or wife Ida B. Wailes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 9 1861

8. AGE: Years	Months	Days	If less than one day
85	11	22	..... hrs. ..... min.

9. Birthplace Wash. D.C.
(Town, county, and state)

10. Usual occupation Merchant retired

11. Industry or business Cigar Store

FATHER 12. Name Isaac Wailes

FATHER 13. Birthplace Wash. D.C.

MOTHER 14. Maiden name ?

MOTHER 15. Birthplace ?

18. Informant Mrs Hortense Wailes

Address 5418 McKinley St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4-1946 (month) (day) (year)

Cemetery or crematory Congressional.

Location D.C.

18. Funeral director S. B. Davis Co.

Address 2901 14st N.W.

19. 5/1 (Date rec'd by registrar) 19 46 Wm E Golden Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 19 46 at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 30, 19 46, to May 1, 19 46 and that I last saw h... alive on Apr. 30 19 46.

	DURATION
Immediate cause of death acute myocardial insufficiency	7 days.
Due to Chr. arteriosclerosis	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. S. Bamford M.D. M. D. or other

Address May 1, 1946 Date signed 5/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176-c)

CERTIFICATE OF DEATH

15514

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: Suburban Hosp.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1821 Calvert St N.W. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Ben Watts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 27, 1890

8. AGE: Years	Months	Days	If less than one day
56			hrs. min.

9. Birthplace: Caleyville, Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: George Watts
13. Birthplace: Md
MOTHER 14. Maiden name: Mary V. Thomas
15. Birthplace: Md.
16. Informant:
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30, 1946 (month) (day) (year)
Cemetery or crematory: Good Hope Ch. Cem.
Location: Caleyville, Md.
18. Funeral director: R. L. Snowden
Address: Rockville, Md.
19. 5/30 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1946, at 4:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec Med Exam case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture of 1st dorsal vertebra with injury to	5 days
Due to cord	accidental
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 5-22-46
Where did injury occur? Chevy Chase (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?): street
Means of injury: fell from truck Injured at work? yes

23. SIGNATURE: Frank J. Brockhurst M.D. M. D. or other
Address: Dept Med. Exam. Washington, D.C. Date signed: 5-26-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

05015

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~HOSPITAL OR INSTITUTION~~ or street address where death occurred:
7929 Georgia Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7929 Georgia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: NEWTON A. WOODSON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Katherine Emery
6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): January 17th. 1861

8. AGE: Years	Months	Days	If less than one day
85	3	22	....hrs. ....min.

9. Birthplace: Grayville, Ills.
(Town, county, and state)

10. Usual occupation: Retired Gov't. Employee

11. Industry or business

FATHER
12. Name: Albert G. Woodson
13. Birthplace: Illinois

MOTHER
14. Maiden name: Adeline R. Randall
15. Birthplace: Illinois

16. Informant: Mrs. Hazel Nevitt (neice)
Address: 7929 Ga. Ave. Silver Spg. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-13-1946 (month) (day) (year)
Cemetery or crematory: Rockville Union
Location: Rockville, Md.

18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.

19. May 11 1946 (Date rec'd by registrar) Josephine M. Shaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1946, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to May 9 1946
and that I last saw him alive on May 3 1946

	DURATION
Immediate cause of death: Cardiac failure	
Due to: Cardio-Vascular-Renal Disease	Several yrs
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: Lynwood Beigs M.D.
M.D. or other
Address: 6990 Riggs Rd. Hyattsville Md. Date signed: 5/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

05015

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 709 Flower Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles H. Wurdeman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): March 20, 1884

8. AGE: Years	Months	Days	If less than one day
62			____ hrs. ____ min.

9. Birthplace: Washington DC (Town, county, and state)
10. Usual occupation: Paper Hanger
11. Industry or business

FATHER
12. Name: Charles H. Wurdeman
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Volland
15. Birthplace: Germany

16. Informant: Gertrude Wilson
Address: 1232 Noyes Drive Silver Spg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27 1946 (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington D.C.

18. Funeral director: Deal Funeral Home
Address: 4812 Ga Ave N.W. DC

19. May 24 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1946, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to May 24 1946
and that I last saw him alive on May 24 1946

Immediate cause of death	DURATION
Cardiac Collapse	few min.
Due to: Hypertensive Heart	
Due to: Cardio-vascular-renal disease	
Other conditions: Pernicious	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Kenwood Heiges M.D.
M. D. or other
Address: 6940 Piney Br. Rd. Date signed: 5/24/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING